Boston Express

Half-Fare Program

Effective: August 2008
Revised: December 2017

Individuals who qualify for Boston Express' Half-Fare Program are entitled to ride our regular fixed route coaches for one-half the regular adult full fare. Half-fare rates apply during any scheduled Boston Express fixed route service.

Who is eligible?

The Half-Fare Program is available for those individuals who are 65 years of age or older, for individuals who are Medicare recipients, or for those who have a physical or mental disability that is verified by a licensed physician.

How do I qualify?

All individuals with disabilities must fill out the Half-Fare Program application and need to be in possession of a Half-Fare Card issued by Boston Express prior to traveling.

- Medicare cardholders must complete and sign part I of the application form. A copy of your Medicare card must be included with your application.
- Persons with disabilities who are not 65 years of age or older and who do not have a Medicare card must complete and sign Part I and must also have a licensed physician fill out and sign Part II.

Instructions on obtaining a Half-Fare Card:

The completed and signed application form, along with one other supporting document to include a photo ID, a driver's license, State ID, or birth certificate, can be submitted at any location or you can mail your application to: Londonderry Transportation Center, 4 Symmes Drive, Londonderry, NH 03053. Forms are available online (www.bostonexpressbus.com) or at our agencies.

The applications will be reviewed at the Londonderry Transportation Center and cards will be issued upon acceptance into the program. Please allow 5 business days for processing. Individuals must submit the completed application form and be approved before a Half-Fare Card will be issued.

Please note: The Half Fare card is required and must be shown with ID when purchasing a ticket to receive half-fare privileges.

Persons 65 years of age or older are not required to fill out the application. A regular picture ID is required at the time of purchase to receive half-fare privileges.

Card replacement

There is no charge for the original ID card. If your card is lost or stolen, please notify Boston Express immediately by calling 1-800-639-8080. Replacement cards will be issued at a cost of $2.00 per card. Cards are non-transferable. Cards used improperly will be confiscated and privileges will be revoked.

If there are any questions about the Half-Fare Program, please call 1-800-639-8080 daily.

Boston Express
HALF-FARE PROGRAM
APPLICATION FORM - PART I

Name: _____
Last First Middle Initial

Address:_____
Street

_____
City State Zip

Phone : (_____)_____

I am applying for a Half-Fare Program I.D. card because:

Check one:

A. I have a Medicare Card ☐
Please include copy of Medicare Card with application

B. I have a legally-documented disability ☐
A physician must complete Part 2 of the application

I certify that the information provided is true and agree to release this information to Boston Express for the purpose of obtaining Half-Fare Program Card. I understand the card is for my personal use and is not transferable to any other person. I grant Boston Express permission to verify the information given on Parts 1 and/or 2 of this form.

_____ _____
Signature of Applicant Date

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HALF-FARE PROGRAM
APPLICATION FORM - PART II

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To be completed by a physician only.

To be eligible for the Boston Express Half-Fare Program, your patient/client must have a physical or mental condition that falls within the medical criteria listed below. If you confirm that the patient/client is physically or developmentally disabled, that person will be eligible for reduced fares on Boston Express bus services. Persons will not be eligible for reduced fares if their sole incapacity is pregnancy, obesity, acute or chronic condition due to drugs, alcohol, or any contagious disease. All information will be held confidential.

Please circle the number which applies to the applicant's condition:

Physical Disabilities

1. Restricted Mobility: Disabilities requiring the use of a cane, crutches, leg braces, walker, or other orthopedic devices used to assist an individual in moving about
2. Arthritis: The American Rheumatism Association criteria may be used for the determination of arthritic disability. Therapeutic Grade III, Functional Class III, Anatomical State III, or worse are evidences of arthritic disability.
3. Loss of Extremities: Anatomical deformity, amputation of both hands, one hand and one foot, or loss of major function
4. Cerebrovascular Accident: Ongoing debilitating effect which follows on occurrence of a cerebrovascular accident
5. Cardio-pulmonary Disease: Serious loss of heart or lung reserves as shown by X-ray, EKG, or other tests, and in spite of medical treatment, there is breathlessness, pain or fatigue
6. Dialysis: The use of a kidney dialysis machine in order to live
7. Acquired Immunity Deficiency Syndrome: AIDS/HIV positive

Visual Disabilities

8. Legally Blind: Visual impairment that is bilateral and not correctable with lenses
9. Contraction of Visual Field: Widest diameter of an angular distance of 20 degrees, or less than 10 degrees from point of fixation, or a visual field efficiency is 20 degrees or less

Hearing Disabilities

10. Legally Deaf: Hearing impairment that is bilateral and not correctable with a hearing aid

Mental Disabilities

11. Developmentally Disabled: A mental disability that originates before age twenty-two
12. Adult Intellectual Disability
13. Epilepsy (grand mal or psychomotor): Anyone who is seizure-free for a continuous period of six months is disqualified
14. Autism: Monotonously repetitive motor behavior, severe withdrawal, inappropriate response to stimuli, and very inadequate social skills
15. Neurological Disabilities: Neurological and physical impairments not controlled by medication (such as cerebral palsy or multiple sclerosis)
16. Organic Brain Syndrome or Emotionally Disturbed: A chronic illness or disturbance that requires boarding or home care or a funded work activity or workshop
17. Other_____

_____

_____

APPLICATION FORM - PART II

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Is disability permanent? Yes ☐ No ☐
(If temporary, please indicate the month/year temporary disability ends: _____)

I hereby certify that the applicant, _____, is disabled as defined by the preceding criteria and that the information contained on this form is true.

Physician's Name: _____
(please print)

Physician's Signature: _____

Date: _____ Telephone No.: _____

REQUIRED FOR PROCESSING
Office stamp (Physician's office)